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Case Report

Medical confidentiality versus disclosure: Ethical and legal dilemmas

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ABSTRACT

A case is described of a fifty year old single man who made disclosures about criminal sexual practices during a psychiatric assessment. In common practice with other professional men, a doctor is under a duty not to disclose, without the consent of his patient, information which he has gained in his professional capacity other than in exceptional circumstances. We discuss the ethical and legal considerations surrounding issues of medical confidentiality and the dilemma that sometimes face clinicians, when they feel obliged, in the public interest, to disclose information they have gained in confidence. Breach of confidences can have deleterious consequences; particularly for the doctor–patient relationship, but failure to disclose in some situations could have serious implications for the well-being of the wider society. Doctors should be aware of the basic principles of confidentiality and the ethical and legal framework around which they are built.

1. Introduction

The establishment of a trusting and honest relationship between doctor and patient has been enshrined in codes of professional ethics from the Hippocratic Oath onwards, including the international code of medical ethics and the declaration of Geneva.[1] A breach of confidentiality is a disclosure to a third party, without patient consent or court order, of private information that the doctor has learned within the patient–doctor relationship.[2] Research shows that when groups of adolescent[3] and adult[4] patients were asked whether they would seek medical care or divulge personal information without a promise of confidentiality, many said no. Indeed, good medical practice requires that patients be confident that their shared information, whether good or bad, repugnant or pleasant, honourable or shameful, will be kept secret.

Dilemmas around confidentiality arise when the principle of confidentiality is in possible conflict with other ethical principles such as avoiding harm to the patient or others.[5] Sometimes therefore, possible harm to others will override the duty of confidentiality to a patient. However, a careful risk-benefit analysis must be made before such disclosures.[6]

We report a case which involved potential harm to wider society including children, which posed clinical and legal dilemmas regarding disclosure issues.

2. Case report

Mr. A, a fifty year old single man had had a history of two psychiatric admissions in 1989 with referential ideas, anxiety and preoccupation with sexual fantasies which he had began to act out. He had then been diagnosed with schizophrenia and treated on various doses of depot Flupenthixol IM two weekly over the years until his transfer to the new psychiatric team.

During Mr. A's assessment in October 2005, Mr. A had complained of anxiety and somatic symptoms. He said that he masturbates every night in order to get to sleep and that if he did not masturbate in 5 days, he would get emotionally rigid. He stated that he started masturbating when he was 12 years old and that the experience has always been associated with heterosexual fantasies. Mr. A, said that he had had at least 15 relationships of some duration but that in only two of these relationships did he have penetrative sexual intercourse. He stated that he was in a two and a half year relationship with a 41-year old woman and that they engage in mutual masturbation and oral sex but not penetrative sex. Mr. A said he usually watch pornographic films 5 days per week and explained that he uses it as an aid to masturbate. He stated that he preferred watching scenes of oral sex, in particular those which depict vigorous activity.

Mr. A also stated that he started exhibiting himself in the late 1970's and he described one incident when he exposed his genitals to a middle-aged woman in a laneway whilst masturbating. He said that he used to masturbate in public places including parks and shops. Mr. A said that on at least four occasions recently, he had telephoned the Samaritans whilst masturbating and recounted

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fictitious stories of being the victim of sexual abuse. He however denied being a victim of childhood abuse including sexual abuse. He also said he had had recent urges to exhibit and masturbate in public but stated that he had managed to control himself.

He described one occasion in his late teens or early twenties in which he put a four year old girl's hand in his trousers for sexual stimulation. However, he denied any further incidents involving children or current sexual fantasies or preoccupation with children. He describes his sexual fantasy life as centring on consensual heterosexual sexual activity.

Other relevant history, including past medical history, family history, personal history and forensic history were not significant.

A Forensic opinion in June 2006 indicated that Mr. A was not suffering from any severe or enduring mental illness, and that he appeared to derive some gain or satisfaction from describing his sexual history to a number of mental health professionals over many years and that health professionals had provided him with proxy audience to whom he has, 'psychologically exhibited' himself. The opinion indicated that Mr. A poses an immutable and static risk to children, but that factors which may impinge upon static risks, including mental illness, use of intoxicants or change in psychological milieu were not present in his case. It also indicated that, there was no rational for pharmacological treatment strategies because of the absence of major mental illness. It recommended that legal advice be sought about disclosure to the police.

As a result of the above, a legal opinion was sought which indicated that Mr. A's level of risk sufficiently justified a breach of confidentiality in the Irish context. Consequently, Mr. A was advised that a disclosure to community care/social services would be made in accordance with national guidelines. A formal report was then made regarding his history of child sex abuse to the area child care manager of social services for them to investigate further. Subsequently, as Mr. A has refused to give any further details of the abuse to an investigative team, it is considered that there is insufficient evidence for Mr. A to be charged with any offence at this stage. However, his access to children and general risk to the public is being monitored by social services.

3. Discussion

The right to confidentiality is recognised by Article 8 of the European convention on human rights[7], although this allows member states to override where appropriate. The Irish Medical Council[8] defines confidentiality as a time-honoured principle of medical ethics which extends after death and is fundamental to the doctor–patient relationship. In common with other professionals, for instance a priest, a doctor is under a duty not to disclose, without the consent of his patient, information which he has gained in his professional capacity other than in exceptional circumstances.[9] Accordingly, there is a well established and well understood presumption in favour of confidentiality. Compelling reasons are therefore necessary in order to justify disclosure by a health care professional of information acquired in practice. What constitutes 'good reason', however, is not so well understood and health care professionals encounter moral dilemmas and intellectual puzzlement.[10]

In the case of Mr. A, he admitted to putting a four year old girl's hands in his trousers for sexual stimulation in clear breach of Section 1 of the Irish Criminal Law Amendment Act, 1935[11] which states; 'Any person who unlawfully and carnally knows any girl under the age of fifteen years shall be guilty of a felony, and shall be liable on conviction thereof to penal servitude for life or for any term not less than three years or to imprisonment for any term not exceeding two years'. Similarly, the UK Sexual Offences Act 2003 stipulates that causing or inciting a child to engage in sexual activity is an offence which if convicted on indictment, carries a punishment of imprisonment for a term not exceeding 14 years.[12] Again, Article 134 of the criminal code of the Russian Federation[13] also makes illicit sexual relations or other sexual actions with a person who has not reached the age of 16 years of age a crime punishable by restraint of liberty for a term of up to three years or deprivation of liberty for a term up to four years. Similar provisions exist in the criminal codes of several countries around the world including Greece[14], Slovenia[15], Malta[16], and the Republic of Romania.[17]

It is unambiguous that there is international consensus amongst at least the countries listed above on the criminalisation of the defilement of minors, although the prescribed punishment for perpetrators varies from one jurisdiction to another. Mr. A would therefore be criminally culpable in all these jurisdictions if his self confessed sexually lewd act with a four year old child were to come to light.

Mr. A had also admitted to exhibiting in public places and in one incident exposing to a middle aged woman in a laneway. He had also admitted to recent impulse to sexually exhibit in public. Unlike the Sexual Offences Act 2003 of the UK, the Irish Criminal Code does not explicitly refer to sexual exposure or exhibitionism as an offence. However, Section 16 of the Irish Criminal Law Amendment Act, 1935[11], makes it an offence for a person to loiter in any street, thoroughfare, or other place and importune or solicit passers-by for purposes of prostitution or being otherwise offensive to passers-by.

It is evident from the self confessed criminal deeds of Mr. A, that he poses an immutable and static risk to children, however, factors which may impinge upon his static risks, are not present. The question that arises is; how serious should a criminal disclosure, or risk to the public be, before breach of confidentiality could be justified according to ethical and legal principles.

The Irish Medical Council[8] lists four circumstances where exceptions may be justified to breaches of confidentiality in the absence of permission from the patient, namely;

(1) When ordered by a Judge in a Court of Law, or by a Tribunal established by an Act of Parliament.
(2) When necessary to protect the interests of the patient.
(3) When necessary to protect the welfare of society.
(4) When necessary to safeguard the welfare of another individual or patient.

Comparable guidelines can be found in other jurisdictions such as the UK, Australia and the USA. In the UK, the General Medical Council (GMC) 2004 publication; 'Confidentiality: Protecting and Providing Information'[18] stipulates that, disclosure of personal information without consent may be justified in the public interest where failure to do so may expose the patient or others to risk of death or serious harm. It explains that such situations may arise, for example, where a disclosure may assist in the prevention, detection or prosecution of a serious crime, especially crimes against the person, such as the abuse of children. It recommends that one should generally inform the patient before disclosing the information.

In this respect, the guidelines given by the GMC appear to be more elaborate when compared with those listed by the Irish Medical Council. However, the Department of Health and Children in Ireland, in its publication, 'Children First National Guidelines for the Protection and Welfare of Children, September 1999'[19], emphasises that giving information to others for the protection of a child does not constitute a breach of confidentiality. Again, in Ireland, the Protections for Persons Reporting Child Abuse Act, 1998[20] provides immunity from civil liability to persons who report child abuse 'reasonably and in good faith' to designated officers of health boards or any member of the Police. This Act is consistent with Sec-

tion 8 of the Irish Data Protection Acts 1988 and 2003[21] which permits disclosure of personal information when it is required for the purpose of preventing, detecting or investigating offences, apprehending or prosecuting offenders or when required urgently to prevent injury or other damage to the health of a person.

In contrast with the Irish and UK Medical Councils, the Australian Medical Council does not give any guidelines regarding disclosure in the public interest. However, the Australian Medical Association's Code of Ethics-2004,[22] stipulates that exceptions to patients confidentiality may be taken seriously and may include where there is a serious risk to the patient or to another person, where required by law or where there is overwhelming societal interest. Similarly, the American Medical Association[2] upholds patient confidentiality and lists exceptions to the rule to include where a patient threatens bodily harm to himself or herself or to another person. Both the GMC in the U.K and the American Medical Association recognises that issues regarding disclosure in the public interest are a matter ultimately for the courts and that ethical guidelines are not binding by law, although courts have used ethical obligations to impose legal obligations.[2,18]

In the case of Mr. A, considering the ethical and legal obligations to disclose, one school of thought believes that disclosure was necessary given the incriminating nature of his admissions and the potential risk that he poses to children. They contend that, consistent with guidelines issued by the Irish Medical Council and the Irish children first national guidelines for the protection and welfare of children, disclosure to the police was necessary to protect the welfare of society at large and children in particular. Again, Article 3 of the United Nations convention on the rights of the child[23] makes it clear that in any proceedings relating to children, their interests are paramount and that the state has an obligation to ensure that the child has such protection or care as is necessary for his or her protection. Ireland is party to this UN convention and Irish legislation provides for this protection through Section 24 of the Child Care Act 1991.[24]

In considering the doctrine of judicial precedence, this school of thought also cite the case of W v Egdell[25], in which an English court of appeal upheld a doctor's disclosure of confidential information in the public interest. They contend that it could be argued, that Mr. A also pose a real and serious risk to others including children and that breaking confidence was the only effective means of avoiding or minimising that harm in his case. This school of thought contend that the public interest argument is almost certainly not only going to be engaged put ultimately prevail when a potential risk to children is identified.

Another school of thought argues that breach of confidentiality in this case was not justified given that any risk Mr. A may pose to society is not imminent and factors which may impinge upon his static risks are not present. They also believe that the guidelines issued by the Irish Medical Council are vague, but that its extension to cover any theoretical risk to the public such as in the case involving Mr. A is inappropriate. In Mr. A's case, they contend that as no victim or potential victims are identifiable, no proximity can be established and no duty of care can be said to exist.

They cite the case of Palmer v Tees Health Authority[26] in which a four year old girl had been abducted, sexually assaulted and killed by a man who had been diagnosed as suffering from a personality disorder. The child's mother claimed that Tees Health Authority had been negligent by releasing the man into the community. However, the hospital trust successfully had the case dismissed by claiming that they did not have a responsibility to look after the girl because the man had not threatened her. The Court of Appeal held that it was not enough to show that any child was at risk from him or that she was at increased risk because she lived near to him.

This school of thought also cite the case of X v Y, in which an English court ruled that the confidentiality of the hospital records was more important than the freedom of the press to publish such information based on theoretical risks to the public posed by two NHS doctors who had AIDS.[27] A similar verdict was made in the case of H v Associated Newspapers Ltd.[28] Again, in the UK, findings of an inquiry into why a convicted murderer freed from prison was able to abduct and rape a 10-year-old boy will remain secret because its publication would infringe the killer's right to privacy.[29]

They further argue that the fear of prosecution, or disgrace following from disclosure, especially in cases where there is no identifiable victims or imminent risk to named individuals, could deter people in a similar situations as Mr. A from seeking medical help.

4. Conclusion

The duty of confidentiality is relative, not absolute and there is no single collection of ethical guidelines or laws, clarifying every ethical or legal issue arising from the confidentiality of medical records. Breach of confidences can have deleterious consequences; particularly for the doctor–patient relationship, but, failure to disclose in some situations could have serious implications for the well-being of the patient or the wider society. Disclosure could be beneficial both to the victim and the perpetrator especially if the victim or intended victim can be identified. As in the case of Palmer v Tees Health Authority[26], when there are general concerns about risk to the wider community without an identifiable victim, decisions about disclosure will often involve a difficult balance. On the one hand disclosure could have an adverse effect on the therapeutic relationship but on the other hand failure to disclose could place vulnerable sections of society at risk.

In Ireland, there exist clear ethical and legal guidelines that permit breaches to patient confidentiality when there is an imminent risk or danger to the patient or other persons. Such guidelines have been published by the Irish Medical Council and in Irish legislation including; the Data Protection Acts 1988 and 2003, the Child Care Act of 1992, and the Protections for Persons Reporting Child Abuse Act, 1998. Paramount consideration is also given to the welfare and safety of children in Ireland, with the children first national guidelines for the protection and welfare of children clarifying how suspected cases of child abuse should be investigated and dealt with. However, none of the existing guidelines addresses the specific issue of breaches to patient confidentiality in suspected cases of child abuse when there is no identifiable victim as in the case of Mr. A, and how such cases should be handled. It is however reasonable to conclude, given the importance attached to the safety and welfare of children in Ireland, that doctors should always err on the side of caution and report such matters to the appropriate authorities as happened in Mr. A's case. Clinicians should not hesitate to seek legal advice when in any doubt regarding this issue.

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Ethical approval

No ethical approval is needed as it is a short report.

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